

# Recommendations for Long-Term Care Facilities during COVID-19 Pandemic



The New Jersey Department of Health (NJDOH) has developed this guidance to assist long term and residential care facilities in response to the 2019 novel coronavirus disease (COVID-19) outbreak. Given the congregate nature of long-term care facilities (LTCF) and residents served (e.g., older adults often with underlying chronic medical conditions), this population is at an increased risk of serious illness when infected with COVID-19. LTCF have experience managing respiratory infections and outbreaks among residents and healthcare personnel (HCP<sup>1</sup>) and should apply those outbreak management principles, in addition to heightened measures within, to COVID-19. **Please note this is a rapidly evolving situation and as more data become available this guidance may change.** Additional resources on how LTCF can prepare for and manage COVID-19 can be found here: <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>.

## Identify Plan and Resources

**Review and update your CMS “all -hazards emergency preparedness program and plan” which includes emergent infectious diseases.**

- If you do not have a plan, a template can be found at [https://www.ahcancal.org/facility\\_operations/disaster\\_planning/Documents/EID\\_Sample\\_Policy.pdf](https://www.ahcancal.org/facility_operations/disaster_planning/Documents/EID_Sample_Policy.pdf).
- Review CDC’s COVID-19 Preparedness Checklist for Nursing Homes and other LTCF at [https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist\\_3\\_13.pdf](https://www.cdc.gov/coronavirus/2019-ncov/downloads/novel-coronavirus-2019-Nursing-Homes-Preparedness-Checklist_3_13.pdf).
- Review the Occupational Safety and Health Administration (OSHA) Guidance on Preparing Workplaces for COVID-19 at <https://www.osha.gov/Publications/OSHA3990.pdf>.

**Identify public health and professional resources.**

- Locate a local health department (LHD) contact using the NJDOH – Local Public Health Directory at <http://www.localhealth.nj.gov/>.
- Contact NJDOH at [https://www.nj.gov/health/cd/topics/covid2019\\_questions.shtml](https://www.nj.gov/health/cd/topics/covid2019_questions.shtml) or via phone during regular business hours at (609) 826-5964 for questions, and after hours/weekends at (609) 392-2020 for emergencies.
- Connect with state long-term care professional/trade association resources.
- Assign one person to monitor public health updates from federal, local, and state entities: \_\_\_\_\_

**Identify contacts at local hospitals in preparation for the potential need to hospitalize facility residents or to receive discharged patients from the hospital.**

- If a resident is referred to a hospital, coordinate transport with the hospital, LHD, and medical transport service/emergency medical service to ensure that the resident can be safely transported and received by the facility.
- **Opening bed capacity in hospitals is vitally important as the outbreak spreads.**
- A list of New Jersey state hospitals can be found at <https://healthapps.state.nj.us/facilities/acFacilityList.aspx>.

## Protecting Residents, Visitors, and HCP

**Provide education about respiratory infections, including COVID-19.**

- Educate on potential harm from respiratory illnesses to nursing home residents, and basic prevention and control measures for respiratory infections such as influenza and COVID-19.
- Include the following topics in education:
  - Hand hygiene: <https://www.cdc.gov/handhygiene/providers/index.html>
  - Respiratory hygiene and cough etiquette: <https://www.cdc.gov/flu/professionals/infectioncontrol/resphygiene.htm>
  - Extended use of Personal Protective Equipment (PPE): <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>
- CDC COVID-19 Print Resources: <https://www.cdc.gov/coronavirus/2019-ncov/communication/factsheets.html>

### Develop criteria and protocols for screening and/or restricting entrance to the facility.

- Ill visitors and HCP are the most likely sources of introduction of COVID-19 into a facility. **CDC recommends aggressive visitor restrictions and enforcing sick leave policies for ill HCP**, even before COVID-19 is identified in a community or facility.
- **Implement universal source control measures for all persons entering the facility (e.g., clergy, vendors, visitors).** Restrict surgical and isolation facemasks for use by HCP – per CDC Strategies for Optimizing the Supply of Facemasks: Contingency Capacity Strategies.
- **On March 13, 2020 the Center's for Medicare & Medicaid Services (CMS) instructed that Facilities should restrict visitation of all visitors and non-essential HCP, except for certain compassionate care situations, such as an end-of-life situation.**
- Communicate with families to advise them of visitor restrictions and consider using alternative methods for visitation (e.g., video conferencing) during the next several months. A sample communication letter can be found at <https://www.cdc.gov/coronavirus/2019-ncov/downloads/healthcare-facilities/Long-Term-Care-letter.pdf>.
- Consider creating list serve communication to update families, assigning staff as primary contacts for families for inbound calls and conducting regular outbound calls to keep families up-to-date, offering a phone line with a voice recording updated at set times each day with the facilities general operating status such as when it is safe to resume visits.
- When allowed (e.g., end of life situations), visitors should be screened for fever **and other symptoms of COVID-19<sup>2</sup>**. Those with symptoms or unable to demonstrate proper infection control techniques should not be permitted to enter the facility.
- Any visitors that are permitted and screened should use **source control measures** while in the building, perform frequent hand hygiene, and restrict their visit to a designated area.
- **Advise any persons who entered the facility to monitor for fever and other COVID-19 symptoms for at least 14 days after exiting the facility. If symptoms occur advise them to self-isolate at home, contact their healthcare provider, and immediately notify the facility of the date they were in the facility, the persons they were in contact with, and the locations within the facility they visited.**

### Review, implement, and reinforce an infection control plan for preventing communicable disease among residents, visitors, and HCP. The plan should include:

- **Transparent communication to staff and families regarding identification of a COVID-19 case and/or outbreak and actions taken.**
- Enact a policy defining what PPE should be used by visitors.
- Before visitors enter the designated area, staff will provide instructions to visitors on hand hygiene, limiting surfaces touched, and appropriate use of PPE.
- Maintain a record (e.g., a log with contact information) of all people who enter the room. If a common area is used, cleaning and disinfection should be performed between visits.
- Ensure visitor movement is limited within the facility (e.g., avoid the cafeteria and other gathering areas).
- Review the CMS Quality, Safety & Oversight (QSO) Group memo Ref: QSO-20-14-NH at <https://www.cms.gov/files/document/qso-20-14-nh-revised.pdf> and the NJDOH COVID-19 Temporary Operational Waivers and Guidelines at <https://www.nj.gov/health/legal/covid19/> for expanded recommendations.
- A policy for when HCP should use Standard, Droplet, and Contact Precautions for residents with symptoms of respiratory infection unless the suspected diagnosis requires Airborne Precautions (e.g., tuberculosis).
  - **For suspect or confirmed COVID-19 case(s) Standard and Transmission-based Precautions including use of a N95 respirator (or facemask, if unavailable), gown, gloves, and eye protection is recommended.**
  - CDC guidance states that **facemasks are an acceptable alternative when the supply chain of respirators cannot meet the demand. When available, respirators (instead of facemasks) are preferred; they should be prioritized for situations where respiratory protection is most important (i.e., procedures that are likely to generate respiratory aerosols)** and for the care of residents with pathogens requiring Airborne

#### Precautions (e.g., tuberculosis, measles, varicella).

- Use respiratory protection as part of a **comprehensive respiratory protection program** that meets the requirements of OSHA's Respiratory Protection standard ([29 CFR 1910.134](#)) and includes medical exams, fit testing, and training. **Consider implementing this program, if not in place.**
- If there are shortages of gowns, they too should be prioritized for aerosol-generating procedures, care activities where splashes and sprays are anticipated, and high contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing of the HCP.
- Implementing and/or maintaining a respiratory hygiene program throughout the facility.
- Utilize telemedicine and alternative means of communication (e.g., telephones, video chat, call bell system, intercoms) to maintain social distancing orders.
- Cohorting residents – See “Person Under Investigation (PUI) and Positive COVID-19 Case(s)”, section below.
- Collection of specimens. Specimens for COVID-19 should not be collected in the facility unless proper infection control precautions can be followed. This includes:
  - Use of a respirator (or facemask, if unavailable), gown, gloves, and eye protection.
  - Performed in an Airborne Infection Isolation Room (AIIR) (e.g., negative pressure room) or in an examination room with the door closed. Ideally, the resident should not be placed in any room where room exhaust is recirculated within the building without HEPA filtration.

#### Restrict the movement of residents throughout the facility.

- Cancel communal dining and all group activities such as internal and external group activities (e.g., physical therapy, beauty shop).
- Restrict residents (to the extent possible) to their rooms except for medically necessary purposes. If they leave their room, residents should practice source control measures (e.g., use of barrier to cover their nose and mouth), perform hand hygiene, limit movement, and perform social distancing (i.e., stay at least 6 feet away from others).
  - All residents, whether they have COVID-19 symptoms or not, should cover their nose and mouth (i.e., source control) when around others, as tolerated. Source control may be provided with tissue or cloth, non-medical masks - when those are available.
- Alternative means of communication and entertainment should be explored to engage residents and comply with social distancing orders.

#### Identify care plan goals and life sustaining treatment plans for residents.

- Review and update care plans to avoid unnecessary emergency room visits and hospitalizations.
- Review National Hospice and Palliative Care Organizations' COVID-19 Shared Decision Making Tool with residents, families, and authorized proxies, available at <https://www.nhpco.org/wp-content/uploads/COVID-19-Shared-Decision-Making-Tool.pdf>.
  - Review symptoms, clinical progression and expected outcomes (e.g., Acute Respiratory Distress Syndrome; mechanical ventilation).
  - Confirm residents' care preferences (e.g., home with palliative or hospice care; remain at LTCF with symptom management; hospitalization for medical intervention; allow natural death).
  - Review and complete Physician Orders for Life-Sustaining Treatment (POLST), available at <http://www.njha.com/polst/>.
  - Advise residents, families, and authorized proxies to review and update Advance Directives at <https://www.state.nj.us/health/advancedirective/>.
- Transfer notification applies to all residents of the facility. If possible, limit transfers to medical necessity.

## Surveillance and Tracking

#### Perform surveillance to detect respiratory infections, including COVID-19.

- Maintain and/or implement protocol(s) for daily monitoring of residents and HCP for fever and other symptoms of COVID-19<sup>2</sup>.

- For tracking residents, McGeer criteria for respiratory tract infections can be found at <https://spice.unc.edu/wp-content/uploads/2017/03/Respiratory-Tract-Infection-Worksheet-McGeer-SPICE.pdf>
- For tracking residents, McGreer criteria for GI tract infections can be found at <https://spice.unc.edu/wp-content/uploads/2017/03/All-GI-Infection-Worksheet-McGeer-SPICE.pdf>
- NJDOH Respiratory Surveillance Line List can be found at <http://nj.gov/health/forms/cds-11.dot>
- CDC's LTC Respiratory Surveillance Line List can be found at <https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf>
- **Note: Your LHD will provide instructions to report COVID-19 cases to public health authorities electronically.**
- Remember that older adults may manifest symptoms of infection differently and that other symptomology should also be assessed at minimum, **once per shift**. Vital signs should include heart rate, blood pressure, temperature, pain and **pulse oximetry**.
- For incoming residents, if possible, dedicate a unit/wing exclusively for any residents coming or returning from the hospital. This can serve as a step-down unit where they remain for 14 days with no symptoms (instead of integrating as usual on short-term rehab floor or returning to long-stay original room). **If a separate wing/unit is not available, use of the "exposed" cohort for asymptomatic admissions may be appropriate, with preferential use of a private room – See "Person Under Investigation (PUI) and Positive COVID-19 Case(s)", section below.**
- **If symptoms are detected, clinicians are strongly encouraged to test for other causes of respiratory illness, including infections such as influenza.** Verify the diagnosis using clinical, epidemiological and lab test information, considering seasonal disease occurrence. Co-infection with COVID-19 is possible and should be considered.

#### **Report any known or suspect communicable disease outbreak, by phone to the LHD with jurisdiction over the facility.**

- Refer to NJDOH Guidelines for the Control of Respiratory Virus Outbreaks in LTCF and Other Institutional Settings at [https://www.nj.gov/health/cd/documents/flu/outbreak\\_prevention.pdf](https://www.nj.gov/health/cd/documents/flu/outbreak_prevention.pdf)
- Your LHD will help assess the situation and provide guidance for further actions, including laboratory testing.

## **Person Under Investigation (PUI) and Positive COVID-19 Case(s)**

### **Determine appropriate placement of PUI and positive COVID-19 case(s) and infection control precautions.**

- For suspect or confirmed COVID-19 case(s), Standard and Transmission-based Precautions including use of a N95 respirator (or facemask, if unavailable), gown, gloves, and eye protection is recommended.
- Implement **facility cohorting plan** that allows for separation of residents, dedicating staff and medical equipment to each of these cohorts and allowing for necessary space to do so at the onset of an outbreak:
  - Identify three cohort groups: 1.) "Ill" 2.) "Exposed" (not ill, but potentially incubating) and 3.) "Not ill/not exposed".
  - Dedicate resident specific equipment and supplies. If not possible, restrict dedicated equipment within a specific cohort with routine cleaning and disinfection between resident use.
  - HCP assigned to affected unit(s) should not rotate to unaffected units. This restriction includes prohibiting HCP from working on unaffected units after completing their usual shift on the affected unit(s).
  - Close the unit to new admissions **except as needed to cohort ill individuals or staff.**
  - Consider closing to new admissions if you are unable to appropriately cohort. This does not include readmissions back to your facility.
  - During an outbreak, public health authorities can provide assistance on a case-by-case basis.
- **If a wing/unit has multiple ill residents, transition the impacted wing/unit to house only these residents when the facility cannot otherwise rapidly isolate them (i.e. "ill" cohort).**
- **If the facility is unable to effectively cohort the impacted wing/unit(s) then rapid isolation of the unaffected wing/unit(s) is imperative.**
- **Consider repurposing unused space such as therapy gyms, activity, and dining rooms during this time.**

- Residents with known or suspected COVID-19 do not need to be placed into an AIIR (e.g., negative pressure room). AIIRs, if available, should be **prioritized for residents undergoing aerosol generating procedures** (e.g., cardiopulmonary resuscitation, open suctioning of airways, nebulizer therapy, sputum induction).
- Place residents with known or suspected COVID-19 in a private room with their own bathroom, with the door closed, (if available) on the COVID + designated wing/unit (i.e., “ill” cohort).
  - Roommates of symptomatic residents may already be exposed; it is generally not recommended to separate them given spatial limitations. **Ensure appropriate use of engineering controls such as curtains between residents to reduce or eliminate exposures from infected individuals.**
  - Residents who are laboratory confirmed COVID-19 + should not be housed in the same room as a person with an undiagnosed respiratory infection.
- To the extent possible, prioritize rounding in a “well to ill” flow to **minimize risk of cross-contamination** (i.e., beginning with standard precaution care areas and working toward transmission-based precaution, then finally outbreak rooms).

#### Implement environmental infection control measures.

- Conduct routine cleaning and disinfection of frequently touched surfaces and shared medical equipment using an EPA-registered, hospital-grade disinfectant on List N (<https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2>). Adhere to internal environmental cleaning protocols to ensure appropriate measures are being taken to clean and disinfect throughout the facility. Consider increasing the frequency of routine cleaning.
- Dedicated medical equipment should be used when caring for a resident with known or suspected COVID-19, when possible.
  - **All non-dedicated, non-disposable medical equipment used for resident care should be cleaned and disinfected** according to manufacturer’s instructions and facility policies.
- **Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.**

#### Enhance active surveillance.

- When a confirmed COVID-19 case is identified at the facility, monitor residents **more frequently.**
- **Clinicians should use their judgment to determine if a resident has signs and symptoms compatible with COVID-19 and whether they should be tested.**
- Seek out additional cases of respiratory illness among residents and HCP. Be alert for new onset of illness among exposed persons, and review resident and HCP histories to identify previous onsets of illness that may not have been correctly recognized as being part of the outbreak.

#### Perform HCP exposure risk assessment for staff who cared for COVID-19 case(s)

- To help facilities document and assess HCP risk and exposure, NJDOH has developed the below series of tools and checklists based on CDC guidance, available at [https://www.nj.gov/health/cd/topics/covid2019\\_healthcare.shtml](https://www.nj.gov/health/cd/topics/covid2019_healthcare.shtml):
  - NJDOH Monitoring and Movement Guidance for HCP Exposed to Confirmed Cases of COVID-19
  - NJDOH HCP Exposure to Confirmed COVID-19 Case Risk Algorithm
  - Retrospective Assessment Tool for HCP Potentially Exposed to COVID-19
  - NJDOH COVID-19 HCP Exposure Checklist
  - NJDOH COVID-19 Fever and Symptom Monitoring Log for HCP
  - HCP Exposure Line List

#### Implement procedure for monitoring HCP working within the facility.

- Screen all HCP at the beginning of their shift for fever and other symptoms of COVID-19<sup>2</sup>. Actively take their temperature and document absence of symptoms.
- **If staff develop even mild symptoms consistent with COVID-19, they must cease resident care activities and notify their supervisor or occupational health services prior to leaving work.**



- HCP who work in multiple locations may pose higher risk and should be asked about exposure to facilities with recognized COVID-19 cases.
- Identify HCP who may be at higher risk for severe COVID-19 disease and attempt to assign to unaffected units.

## HCP Health and Contingency Planning

### Evaluate and manage HCP with symptoms of illness.

- Implement sick leave policies that are non-punitive, flexible, and consistent with public health measures that allow ill HCP to stay home.
- As part of routine practice, ask HCP (including consultant personnel) to regularly monitor themselves for fever and symptoms of COVID-19<sup>2</sup>. Remind HCP to stay home when they are ill.
- If HCP develop fever or symptoms of COVID-19 while at work, they must cease patient/resident care activities and notify their supervisor or occupational health services prior to leaving work.
- Consult occupational health on decisions about further evaluation and return to work.
- With sustained community transmission consider having HCP wear all recommended PPE for the care of all residents, regardless of presence of symptoms.
- When transmission in the community is identified, LTCF may face staffing shortages. Facilities should develop (or review existing) plans to mitigate staffing shortages. Staffing shortages may be addressed by reviewing the COVID-19 Temporary Operational Waivers and Guidelines at <https://www.nj.gov/health/legal/covid19/> for potential solutions.

### Develop contingency staffing and resident placement plans.

- Identify minimum staffing needs and prioritize critical and non-essential services based on residents' health status, functional limitations, disabilities, and essential facility operations.
- Contact your healthcare coalition for guidance on altered standards of care in case residents need acute care and hospital beds are not available.
- Strategize about how your facility can help increase hospital bed capacity in the community.
- Establish memoranda of agreement with local hospitals for admission to the LTCF of lower acuity residents to facilitate utilization of acute care resources for those more seriously ill.
- Identify facility space that could be adapted for use as expanded inpatient beds.

### Develop strategies for optimizing the supply of PPE.

- Per Executive Order No. 111 - Healthcare Facility Capacity & Supplies Reporting, covered facilities must report data to the New Jersey Office of Emergency Management (NJOEM) by 10:00 am, concerning their capacity and supplies on a daily basis, at <https://report.covid19.nj.gov/>.
- Implement protocols for the extended use of PPE. CDC recommends that all U.S. healthcare facilities begin using PPE contingency strategies as of 4/2/2020. Review CDC's Strategies to Optimize PPE Supply at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html>.
- During times of limited access to respirators or facemasks, facilities could consider having HCP remove only gloves and gowns (if used) and perform hand hygiene between residents with the same diagnosis (e.g., confirmed COVID-19) while continuing to wear the same eye protection and respirator or facemask (i.e., extended use). Risk of transmission from eye protection and facemasks during extended use is expected to be very low.
- Bundle tasks to optimize PPE and limit exposures. Consider cross-training to conserve resources.
- Review CDC's FAQ about PPE at <https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirator-use-faq.html>.

<sup>1</sup>For this guidance, CDC defines HCP as all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices, and equipment; contaminated environmental surfaces; or contaminated air.

<sup>2</sup>Symptoms of COVID-19 may include gastrointestinal upset, fatigue, sore throat, dry cough and shortness of breath; visit <https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html> for more information.